Your Medical Benefit Book

Welcome to Washington State's Health Care Programs

If the enclosed information is not in your primary language, please call 1-800-562-3022 (TDD/TTY only: 1-800-848-5429)
ENG

Yog tas cov ntaubntawv kws tuaj nrug nuav tsi yog koj yaam lug tes thov hu rua 1-800-562-3022 (TDD/TTY xwb: 1-800-848-5429)
HMG

Afai o lenei faaaliga e le o alu atu i lau gagana masani, faamolemole vala'au mai i le telefoni: 1-800-562-3022 (Mo e e le lelei le faalogo pe gugu, vala'au mai i le telefoni 1-800-848-5429)
SAM

Если прилагаемая информация не на вашем родном языке, позвоните, пожалуйста, по телефону 1-800-562-3022 (телефон только для лиц с плохим слухом (TDD/TTY): 1-800-848-5429)
RUS

Якщо прикладена інформація не на вашій рідній мові, подзвоніть, будь ласка, по телефону 1-800-562-3022 (телефон тільки для осіб з поганим слухом (TDD/TTY): 1-800-848-5429)
UKR

동봉한 안내자료가 귀하의 모국어로 준비되어 있지 않으면 1-800-562-3022 (청각장애자/시각장애자용: 1-800-848-5429)로 연락하십시요.
KOR

Dacă informaţiile alăturate nu sunt în limba dumneavoastră natală vă rugăm să sunaţi la 1-800-562-3022 (numai pentru TDD/TTY: 1-800-848-5429)
ROM

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AM

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TIG

Si la información adjunta no está en su idioma primario, por favor llame al 1-800-562-3022 (Para TDD/TTY solamente, llame al 1-800-848-5429).
SP

ຖ້າຫາກວ່າຂ່າວສານອັນນີ້ບໍ່ແມ່ນພາສາທີ່ທ່ານຮູ້ຈັກ, ກະຣຸນາໂທຣະສັບໄປຫາ 1-800-562-3022 (TTY/TDD ເທົ່ານັ້ນ: 1-800-848-5429).
LA

Nếu tin tức đính kèm không có ngôn ngữ của quí vị, xin gọi 1-800-562-3022 (TDD/TTY mà thôi: 1-800-848-5429)
VN

如果隨附的資料不屬你的母語，請打電話 1-800-562-3022（TDD/TTY 專線 1-800-848-5429）。
CHI

បើពត៌មានដែលភ្ជាប់ទៅនេះមិនមែនជាភាសាដើមរបស់អ្នកទេ,សូមទូរស័ព្ទ 1-800-562-3022, (សំរាប់ TDD/TTY, ជនពិតប្ចួង: 1-800-848-5429)
CAM

Kung ang nakalakip na impormasyon ay hindi sa inyong pangunahing wika, pakitawagan po ang 1-800-562-3022 (TDD/TTY lamang: 1-800-848-5429)
TA

اگر اطلاعات ضميمه به زبان شما نمي باشد، لطفا به اين شماره 1-800-562-3022 **(براي** TDD/TTY (1-800-848-5429)
FA

Welcome to Washington State's Health Care Programs

This book explains the Medicaid Healthy Options program.
Please read the book to find out:

- How DSHS pays for your medical care;
- The differences between managed care, PCCM, and fee-for-service;
- Your medical benefits and covered services;
- How to choose a health plan;
- Information about each managed care health plan;
- Well-child doctor visits, childhood immunizations, and follow-up care benefits;
- Your rights and responsibilities;
- How to disenroll from a managed care health plan; and
- Other important information you need to know.

If you have questions:

1. Use the "Webform" or send us an email by using the website at: http://hrsa.dshs.wa.gov/contact/default.aspx
2. Call 1-800-562-3022 or 1-800-848-5429 TTY/TDD or 711 (for people with hearing or speech equipment). The call is free.

We will be glad to help you!

Using the Automated System to Hear Available Health Plans:

Shortcut

Health Plan Enrollment
1-800-562-3022
Press 6 for clients,
then Press 2

What will I hear?

The automated system will play the current health plan information for the person calling or for another family member.

When choosing to hear available health plans, the system will play the plan names and toll free numbers. If family members have different choices, the call will be transferred to an agent.

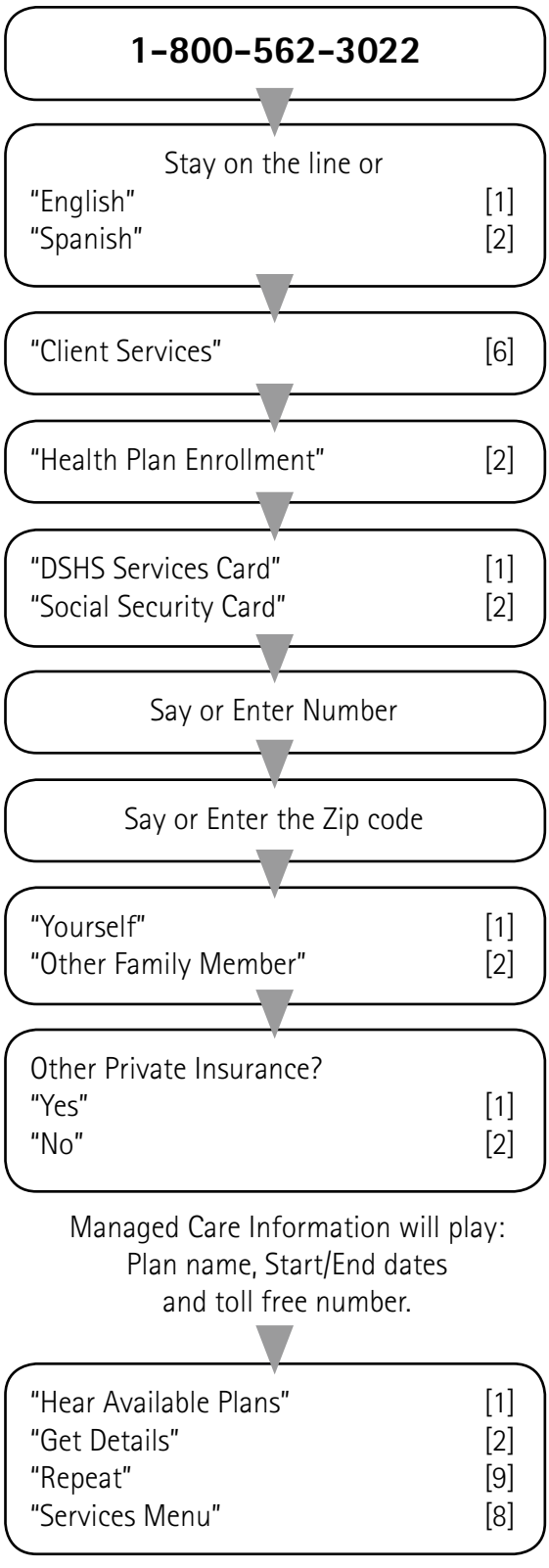
If choosing to "Get Details" information about the current managed care program will be played.

If confirming an assigned plan or enrolling in a different plan, more details can be given:

- Doctor or clinic name
- Pregnancy due date
- Surgery date
- Special needs or chronic condition
- General health rating

How

You can speak or press the number in brackets [ ]. You can key ahead anytime.



Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

Client ID Number:
Name:
Address:

Enrollment Form

Easy as 1-2-3!

1. Please mark one box to show how you want to get health care for the people in your family.

- ☐ MHC
- ☐ CHPW
- ☐ CUP
- ☐ ANH
- ☐ GHC
- ☐ RBS
- ☐ KFHP
- ☐ FEE FOR SERVICE
- ☐ PCCM CLINIC ____________

2. Write the name of the doctor or clinic you would like for each person. All doctors and clinics you list must be in the plan you choose above. Call the doctors to see if they are with the health plan.

Client ID	Client Name (Last, First, MI)	How would you rate this person's Health? Excellent	Very Good	Good	Fair	Poor	Special Health Condition or Developmental Delay? Yes	No
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								
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Doctor or Clinic:								
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Doctor or Clinic:								
		☐	☐	☐	☐	☐	☐	☐
Doctor or Clinic:								

3. Is anyone above pregnant or having surgery?

☐ Pregnant Family Member's Client ID: ____________ Due Date: ____________

Doctor or clinic: ____________

☐ Scheduled for surgery Family Member's Client ID: ____________ Date: ____________

Choose ONE way to let us know your choice.

- Sign up on line: www.WAProviderOne.org
- Call our automated system anytime: 1-800-562-3022
- Fill out, fold and return with the Business Reply address on the outside (no stamp needed)
- Fill out and then fax to: **1-866-668-1214**

If you have questions call 1-800-562-3022,
Monday – Friday 7:00 a.m. to 5:00 p.m.
TTY/TDD users call 711 or 1-800-848-5429

Provider One Number

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 256 OLYMPIA WA

POSTAGE WILL BE PAID BY ADDRESSEE

DEPARTMENT OF SOCIAL & HEALTH SVCS

PO BOX 45505
OLYMPIA WA 98599-5505

If it is hard for you to read or understand this book, please call the medical assistance helpline at 1-800-562-3022. We can help by giving you the information in an alternative format, such as larger print or have it read to you. This book is also available in other languages at no cost to you. You may ask for a copy of the book in Russian, Spanish, or Vietnamese. The TTY/TDD line is 711 or 1-800-848-5429 for people who have difficulties with hearing or speech. Your phone must be equipped to use this line.

Important Contact Information

Asuris Northwest Health	1-866-240-9560
Columbia United Providers	1-800-315-7862
Community Health Plan	1-800-440-1561
Group Health Cooperative	1-888-901-4636
Kaiser Permanente	1-800-813-2000
Molina Healthcare of Washington, Inc.	1-800-869-7165
Regence BlueShield	1-800-669-8791

You can send DSHS Medical Assistance your questions and comments using the website at:

http://hrsa.dshs.wa.gov/contact/default.aspx

Or call:

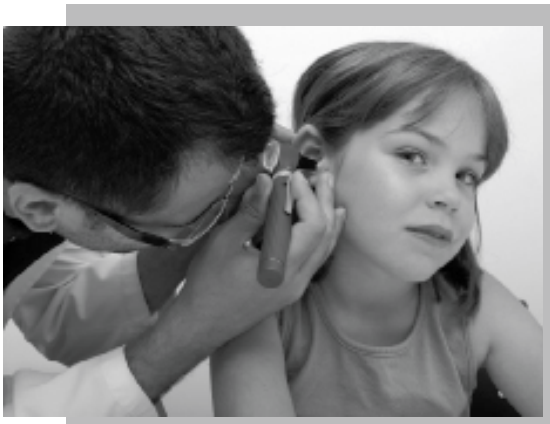
1-800-562-3022

Table of Contents

How do you get your health care?

DSHS is the State of Washington's Department of Social and Health Services. The department provides for your health care in different ways, depending on where you live or what services you get. This book gives you information about how to get your health care when you are enrolled in a managed care program.

Healthy Options health plans: The department has medical managed care insurance programs called Healthy Options. The department contracts with health insurance plans to cover most of your medical care. When you are enrolled in Healthy Options, you pick a plan and go to one clinic or doctor who will be your Primary Care Provider (PCP). Your PCP will give you the care you need or have you go to a specialist. You may still get some services that your health plan does not provide through fee-for-service (such as alcohol and substance abuse services, inpatient psychiatric care or transportation for medical appointments).



Health care from a tribal or urban Indian clinic: If you are American Indian or Alaska Native, you may be able to sign-up for the Primary Care Case Management (PCCM) program. PCCM health services are provided through a tribal or urban Indian clinic. The providers at the clinic know your culture, community, and health care needs. They will give you the care you need or send you to a specialist. If you have questions about the PCCM program, talk to your clinic staff to see if this is a good choice for you.

Fee-for-service (not in a health plan or PCCM): If you are not in a health plan or PCCM, you will have to find the doctor, hospital, or pharmacy that will see patients on medical assistance. This is called fee-for-service (FFS). Sometimes it is hard to find providers who will see patients on medical assistance.

Do you have to be in a Health Plan?

Enrollment in a contracted managed care plan is mandatory for eligible:

- Families receiving Temporary Aid to Needy Families (TANF) benefits,
- Children/parents eligible for continued medical benefits
- Pregnant women
- Children whose parents get their medical care through the State's Basic Health Plan,
- Children through age 19 in the State's Children's Health Insurance Program.

There are some situations when you don't have to be in a health plan. You must let us know before you get in a health plan if one or more of the following situations apply to your case.

- **You have other health insurance** besides DSHS.
- **A child has special health care needs** and is getting services from a public or community health nurse with your county's Children with Special Health Care Needs program.
- **You are homeless** and you will live in a shelter or temporary address for less than four months.
- **You are getting treatment for a medical condition from a doctor or other medical provider who is not with a health plan** AND this doctor tells us the medical reasons why you need to keep getting your care from him or her.
- **You don't speak English or you are deaf or hearing impaired** AND you want to see a doctor or other medical provider who speaks your language AND the health plan does not have a provider available who can speak your language AND no interpreter is available.
- **A child is placed in foster care**;
- **You become eligible for Medicare**;
- **You are American Indian or Alaska Native.** People who are American Indian or Alaska Native do not have to sign up for a health plan. As an American Indian/ Alaska Native, you can choose to sign up for a health plan, a PCCM clinic, or choose fee-for-service. If you are American Indian or Alaska Native, call 1-800-562-3022 and let us know.

What happens if some people in your household are American Indian or Alaska Native and others are not?

Usually, family members who are not American Indian or Alaska Native must be in a health plan. There is one exception. If a family member is American Indian or Alaska Native AND signs up for a Tribal clinic, the other family members may also sign-up for the same Tribal clinic if the Tribal clinic approves. Check with your local Tribal clinic. (See the list of Tribal clinics in this book.)

What are your choices?

Why should you choose a health plan?

Unlike Fee-for-service or PCCM, with a health plan you have access to medical advice 24 hours a day. In a health plan, your primary care provider will help you get preventive care and refer you to specialists if you need them. Also, you may get some extra services like wellness programs with special gifts, such as bike helmets or car seats for your children. To find out more about the health plans, please call the numbers listed on the plan information pages in this book.

Why should you choose Primary Care Case Management (PCCM) if you are American Indian/Alaska Native?

If you are American Indian/Alaska Native you can have your care managed by a provider who knows your culture, community and health care needs. If you have questions about the PCCM program, talk to your clinic staff to see if this is a good choice for you.

Why should you choose a health plan or PCCM if you live in an area where you can choose Fee-for-service?

If you are not in a health plan or PCCM, you may have trouble finding a provider who will give you medical care and bill DSHS for payment (fee-for-service). With a health plan or PCCM, you don't have to worry about trying to find a doctor. You may choose a doctor with the plan or one will be assigned to you. Plus, your doctors will work together to manage all your health needs. If you need to see a specialist, they will arrange it for you without having to find a specialist on your own who accepts fee-for-service patients.

What happens if you do not tell us your choice?

DSHS will pick a plan or PCCM clinic for you. If a plan has been picked for you, you may not be able to use the doctors, hospitals, and other providers you want. Please call your doctor, pharmacy and specialist to see which plans they accept.

Does everyone in your family have to be in the same health plan?

Yes, everyone in your family who is eligible for enrollment in a managed care program has to be in the same health plan unless:

- Your family has American Indian/Alaska Native members, or
- A family member is enrolled in the Patient Review and Coordination (PRC) program.

Note: If you are enrolled in the Patient Review and Coordination program, you need to stay with one health plan for one year. You will remain in this program if you are enrolled in a health plan, PCCM or use fee-for service.

How can you find out more about the plans you can choose from?

First call the health plans to see if they are available where you live. Then look for more information about the health plan(s) in this book. The health plan pages include:

- Where to call if you have questions, and
- How to learn more about what each plan offers.

What if you have doctors, specialists, hospitals, or pharmacies you would like to use?

If there are doctors, specialists, hospitals or pharmacies you would like to use, find out which health plans they are with before you sign up. Some providers are with more than one health plan. Remember, the hospitals you can use depend on which hospitals your doctor and health plan uses.

How do you choose your PCCM?

If you are American Indian/Alaska Native, you should choose the tribal or urban Indian clinic you already go to. See the list of participating PCCM Tribal clinics in this book.

How do you sign up for either a health plan or PCCM?

It's easy! If you want a different plan than the one DSHS chose for you, just fill out the Sign-up form in this book and drop it in the mail. You don't even need a stamp! Or call us using the automated telephone system and tell us which plan you want.

Can you change your health plan?

Yes! In most cases, you can change health plans at any time. The change will be effective the next month. Call DSHS using the automated telephone system and tell us which plan you want.

NOTE: If you are enrolled in the Patient Review and Coordination Program, you need to stay with the same health plan for one year.

What happens if you move?

If you move, you may need to change how you get your care. Be sure to call your local Community Service Office (CSO) to let them know you moved. Also, call your health plan. They will tell you if you need to make changes.

How do you get medical care from your health plan?

After you are signed up, your health plan will send you a plan ID card and assign you to your choice of a Primary Care Provider (PCP). Make an appointment with your PCP for a check-up.

How do you get care in an emergency or when you are away from home?

Emergency care: An emergency is a sudden or severe health problem that needs treatment right away. If you think you have an emergency, no matter where you are, call 911 or go to the nearest location where emergency providers can help you. Emergencies are covered anywhere in the United States. As soon as possible, call your PCP or health plan to arrange for follow-up care after the emergency is over. Your PCP or health plan can help arrange the follow-up care.

Urgent care is care you get when you think you have a health problem that needs care right away, but your life is not in danger. Urgent care is covered anywhere in the United States. If you think you need to be seen quickly, go to an urgent care center. You can also call your PCP's office or the health plan's 24-hour Nurse Advice Line.

Medical care away from home: If you need medical care or need to get prescriptions filled while you are away from home, call your PCP or your health plan for advice. They will help you get the care you need.

How do you get care after hours?

Most health plans have a toll-free phone number to call and get medical advice from nurses 24 hours a day. The phone number to call is listed on the health plan's information page in this book. Call your PCP's office or health plan's Nurse Advice Line for advice on how to reach a provider after hours.

How soon will a health plan provider see you?

How soon your health plan must get you in to see your provider depends on the care you need. Health plan providers must meet certain standards for appointments. You should expect to see a health plan provider within the following timelines:

- **Emergency:** Available 24 hours per day, seven days per week. An emergency is when someone has a sudden or severe medical problem and needs care right away. Call your PCP for any follow-up care after an emergency care visit.
- **Urgent:** Office visits with your PCP or other provider within 48 hours. Urgent care is for medical problems that need care right away, but your life is not in danger. Call your PCP for any follow-up care after an urgent care visit.
- **Routine Care:** Office visits with your PCP or other provider within 10 days. Routine care is planned, regular, provider visits for medical problems that are not urgent or an emergency.
- **Preventive Care:** Office visits with your PCP or other provider within 30 days. Examples of preventive care are physical exams, such as well-child care; annual women's health care; and immunizations (shots).

Consulting Nurse Advice Line: Most health plans have a toll-free phone number to call and get medical advice from a nurse 24-hours day. The phone number to call is listed on the health plan's information page in this book.

Can you go to any doctor, pharmacy, or hospital that you want?

No - You must use doctors and other medical providers who work with your health plan. Health plans also have certain hospitals and pharmacies you must use. For all of the plans, the hospitals you can use depend on which hospitals your doctor uses. Call the plan's customer service line for more information about their doctors, hospitals and pharmacies. If you ask, they can give you a list of providers, pharmacies and hospitals, which includes:

- The service provider's name, location and phone number;
- The specialty and medical degree;
- The languages spoken;
- Limits on the kind of patients the provider sees, and
- If they are accepting new patients.

Who will take care of most of your health care needs?

You will go to one person in your plan for most or all of your care. This person is called your primary care provider (PCP). Your PCP can be a doctor, nurse practitioner or physician assistant. If you want to know about a PCP's medical training, board certification, languages spoken, etc. call your health plan and they will get you the information. If you need care from a specialist or other provider, your PCP will help you find the right specialist and give you a referral.

Can you change your PCP?

Yes! You may choose a different PCP as long as the new PCP is with your health plan. To do this, call your health plan. Most PCP changes will take place the first day of the next month.

Can you and others in your family have different PCPs?

Yes! You and your family members can have different PCPs as long as all of them are in the health plan you pick. Call your health plan to choose the PCP you want.

Yes! You and family members can have different PCPs as long as all of them are in the health plan you pick.

How do you get care from a specialist?

Your PCP must refer you for most of your specialty care. There are some exceptions, so check with your plan to be sure. If you think you need specialty care, contact your PCP. If you or your PCP thinks that you need specialty care, your PCP will refer you to a specialist who works with your health plan. For more information about specialists call your plan's customer service. Your health plan can give you a list of contracted specialists.

What if you need to go to the hospital?

If you think you have an emergency, call 911 or go to the nearest hospital. All planned surgeries and other non-emergency hospital visits must be approved by your health plan in advance. Your provider and the hospital will call your health plan to arrange for your visit. If you need a list of hospitals that work with your health plan, call your plan's customer service.

How do you get prescriptions filled? Can you use any pharmacy?

The health plans contract with many pharmacies. You must get your drugs at one of these pharmacies. Call your health plan's customer service number and ask them to send you a list of their contracted pharmacies.

Will your health plan cover all drugs prescribed?

All health plans use a list of approved drugs. This is called a "formulary." The list is put together by a group of providers and pharmacists. To make sure your drugs will be paid for, your PCP or provider should prescribe drugs to you from this list. You do not have a copay for drugs covered by your health plan. Certain drugs on the list will need approval from your health plan before you get the drugs.

You can call your health plan and ask for:

- A copy of the formulary (drug list).
- Information about the group of providers and pharmacists who created the formulary.
- A copy of the policy on how your health plan decides what drugs are covered.

How do you get mental health care?

If you need mental health care, your PCP can help coordinate your care with a mental health provider. All health plans cover 20 hours of treatment per calendar year for children up to 18 years of age. Adults (19 and older) are limited to 12 hours of treatment per calendar year. Health plans also cover evaluations and, if needed, psychological testing.

Your PCP might think your mental health needs are better served through your local Community Mental Health Agency. If so, your PCP will send you there for an evaluation. If you meet the access standards, you will continue to get all your mental health care needs from the Community Mental Health Agency. Mental health drugs prescribed to you while getting care from a Community Mental Health Agency are covered by DSHS as part of that care. If you do not meet the access standards for care from the Community Mental Health Agency, your PCP and health plan will help you get needed care.

What if you have special health care needs or long-term illness?

If you have special health care needs, you may be eligible for extra benefits in a health plan's disease management program. You may also get direct access to specialists who can help you get needed care. In some cases the health plan may allow you to use your specialist as your PCP. You can get more information about disease management from your health plan.

What if you have a medical service, such as surgery that is already scheduled?

Call the health plan you are choosing right away to let them know about the medical service so they can help you get needed care. There is also a place on the Sign-up form to tell us this information.

Can you get women's health care, without a referral from your PCP?

Yes! You do not need a referral (permission) from your PCP to get pregnancy or other women's health care as long as the provider you choose is in your health plan.

What is EPSDT?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a preventive health care benefit for children and youth. The program provides complete, periodic health screenings to clients under age 21. The screenings can help identify potential physical and/or behavioral health conditions. Diagnostic testing and medically necessary treatment to correct or improve physical and mental illnesses or conditions are also available through the EPSDT program. EPSDT encourages early and continuing access to health care for children and youth.

EPSDT includes:

Screening – When requested, screenings are done according to a recommended schedule to fully assess each child's health status and find possible health problems. Check with your provider for when your child should be screened.

A screening includes all of the following elements:

- Complete health and developmental history.
- A full physical examination.
- Appropriate behavioral health and substance abuse screening.
- Health education and counseling based on age and health history.
- Appropriate vision testing.
- Appropriate hearing testing.
- Appropriate laboratory testing.
- Dental screening services.
- Immunizations (shots).

All EPSDT screening elements must be performed or ordered for the visit to be considered an EPSDT screening.

Diagnosis – When a health care risk is identified in an EPSDT screening, additional tests may be done to determine if further evaluation or treatment is needed.

Treatment – When a health care condition is diagnosed as a result of an EPSDT screening, the provider(s) will:

- Treat the client if it is within the provider's scope of practice; or
- Refer the client to an appropriate provider for treatment which may include:
- Additional testing or specialty evaluations, such as developmental assessment, comprehensive mental health, substance abuse evaluation, or nutritional counseling.
- The provider who treats the patient will share the results with the provider who referred the patient for the EPSDT screening. If there is a need for a more complete evaluation of the client's health or condition, that evaluation, diagnosis, and medically necessary treatment is provided to the client.

Children may receive medically necessary covered health care services with or without an EPSDT screening. Certain covered health care services may require prior authorization. A current EPSDT screening is required before medically necessary non-covered services may be requested and authorized. All non-covered services require prior authorization.

EPSDT encourages early and continuing access to health care for children and youth.

What is your Services card?

Each family member on medical assistance gets a Services card. Your Services card is a permanent card that is activated while you are eligible for medical assistance. The card only includes your name and identification number. You may also need to show a picture ID to prevent unauthorized use of the card. Your providers will verify your eligibility for medical services. If you lose the Services card, call the Medical Assistance Helpline at 1-800-562-3022 and follow the voice response prompts to ask for a new Services card.

What is your health plan ID card?

When you are enrolled in a health plan, you will also get an identification (ID) card from your health plan. You should have **both** your Services card and your health plan ID card to:

- Get medical services
- Make, cancel, or check appointments, and
- Order or pick up prescriptions

Please call your plan's customer service number if any information on the card is wrong, or the card is lost, stolen, or needs to be replaced.

What are your medical benefits?

DSHS covers many benefits and services when medically necessary whether you get health care through a Managed Care health plan, a PCCM clinic, or Fee-for-Service. Some of the benefits covered by the health plans are listed below. For some services you need to get approval from your health plan. Check with your provider or your health plan if a service you need is not listed as a benefit.

For some services, you may need to get a referral (from your PCP) and/or approval from your health plan before you get the services. Otherwise, your health plan might not pay for the service. Some services are limited by number of visits or supply/equipment items. Each health plan has a process to review your or your provider's request for a *Limitation Extension*.

Call your health plan's customer service number before you get medical services or ask your PCP to help you get the care you need.

NOTE: This list is provided for general information only and does not guarantee that the service will actually be covered.

Benefits/services covered by your health plan/PCCM:

Benefit/Service	Comments
Ambulance Services	For emergencies only or when transporting between facilities.
Antigen (allergy serum)	Allergy shots
Audiology Tests	Hearing tests
Biofeedback Therapy	Limited to plan requirements
Birth Control	See Family Planning Services.
Birth Defects	See Cosmetic Surgery.
Blood Products	Includes blood, blood components, human blood products and their administration.
Breast Pumps	
Chemotherapy	
Chiropractic Care for children	Benefit is for children only (age 20 and under) with referral from PCP after being seen for an EPSDT (well child care) screening. See Spinal manipulations.
Contraceptives	See Family Planning.
Cosmetic Surgery	ONLY WHEN - the surgery and related services and supplies are provided to correct physiological defects from birth, illness, physical trauma or for mastectomy reconstruction for post-cancer treatment.
Diabetic Supplies	
Dialysis	
Emergency Services	Available 24 hours per day, 7 days per week anywhere in the United States. An emergency is when someone has a serious medical problem and needs care right away.
EPSDT (means Early and Periodic Screening, Diagnosis and Treatment)	EPSDT includes regular checkups to make sure people under 21 years old get the preventive care they need to catch and treat health problems at an early stage. These EPSDT screenings (well child care) include: • A complete physical exam with health, mental health screening, and developmental history • Immunizations (shots) and lab tests • Screens for: Vision; Hearing; Dental Care; Mental Health; and Substance Abuse.

Benefit/Service	Comments
Eye Exams	You must use the plan's provider network. Limited to one exam every 12 months for children age 20 and under and every 24 months for adults 21 and over. Can be more frequent if determined to be medically necessary by the health plan. **NOTE:** For children - Eyeglasses, Contact Lenses, & hardware fittings are covered by DSHS separately.
Family Planning Services	You have a choice of either going to a Family Planning Clinic or using the plan's network of providers.
Fluoride Treatment Prescription – (liquid/tablets)	When prescribed by physician (PCP) after a well child or EPSDT screening.
Healthcare Services (Office Visits, Preventive Care, Specialty Care)	Must use participating providers with plan. Plans may require approved referrals – Call the health plan for specific questions.
Health Education and Counseling	*Examples: Health education for conditions such as* diabetes and heart disease.
Hearing Exams	Hearing exams are covered by health plan's network of providers. **NOTE:** *For children - Hearing aids are covered separately by DSHS*
HIV/AIDS screening	You have a choice of going to a Family Planning clinic, the local health department or going to your PCP for the screening.
Home Health Care	Must be approved by health plan
Hospital, Inpatient and Outpatient services	Must be approved by health plan for all non-emergent care
Immunizations/Vaccinations	**NOTE:** *Vaccines for international travel purposes only are NOT COVERED.*
Lab and X-ray Services	
Mammograms	See Women's Health Care.
Maternity & Prenatal Care	See Women's Health Care.
Medical Equipment	Call the health plan for specific details.
Medical Supplies	Call the health plan for specific details.
Mental Health, Outpatient Treatment	Limited benefit based on medical need. The benefit through the health plan covers: • Up to 12 hours of treatment per calendar year for adults. • Up to 20 hours of treatment per calendar year for children. • Mental Health medication management by your PCP or mental health provider. • Children under 5 years of age being prescribed mental health medication must have a second opinion from a Psychiatrist to approve the medication. • Psychological testing and evaluation once every 12 months for adults 21 and over, or as needed if identified by an EPSDT (well-child care) screening for children 20 years old and under.

Benefit/Service	Comments
Nutritional Counseling	See health education
Occupational Therapy	Covered for both rehabilitation and developmental reasons. DSHS covers the service for children when provided in an approved Neurodevelopmental Center.
Organ Transplants	Call the health plan for specific details.
Oxygen & Respiratory Services	
Pharmacy Services	Must use participating pharmacies. The health plan's have their own drug formulary (list). Call your health plan for specific information and list of pharmacies.
Physical Therapy	Covered for both rehabilitation and developmental reasons. DSHS covers the service for children when provided in an approved Neurodevelopmental Center.
Pregnancy Terminations, Involuntary (miscarriage)	
Private Duty Nursing	
Radiology & Medical Imaging Services	
Reconstructive Surgery after Mastectomy	
Sexually Transmitted Diseases (STD) Treatment	You have a choice of going to your PCP, the local health department or family planning clinic
Skilled Nursing Facility (SNF)	
Smoking Cessation	Smoking Cessation is covered for all clients based on health plan's policies.
Speech Therapy	Covered for both rehabilitation and developmental reasons. DSHS covers the service for children when provided in an approved Neurodevelopmental Center.
Spinal Manipulations	*Limited Benefit* - Ten (10) spinal manipulations per calendar year are covered by the health plan, only when performed by a plan Doctor of Osteopath (D.O.).
Sterilizations, age 21 and over	Must complete sterilization form 30 days prior or meet waiver requirements. Reversals not covered.
Tuberculosis (TB) Screening & Follow-up treatment	You have a choice of going to your PCP or to the local health department.
Women's Health Care	Services must be obtained from the health plan's network of providers and includes follow-up treatment for any problems discovered.

You have a choice to get some services from your PCP/PCCM clinic or go directly to a local health department or family planning clinic. You do not need a referral (permission) from the health plan for the following services:

- Family Planning services and birth control
- HIV and AIDS testing
- Sexually transmitted disease treatment and follow-up care
- Immunizations
- TB screening and follow-up care

Benefits covered by DSHS fee-for-service:

The following benefits and services are covered by DSHS fee-for-service. Your health plan and PCP can help coordinate your care with other community-based services and programs. If you have a question about a benefit or service not listed here, call your health plan's Customer Service line or the DSHS medical assistance helpline.

Benefit/Service	Comments
Alcohol and substance abuse services, inpatient, outpatient & detoxification	Must be provided by DSHS certified agencies. Call 1-877-301-4557 for specific information.
Community and home-based services for older and physically disabled persons such as COPES and Personal Care Services	These services must be approved by DSHS Aging and Disability Services Administration (ADSA). Call 1-800-422-3263.
Dental Services (see note below)	You must find a dental provider who will bill DSHS.
Eyeglasses and fitting services (see note below)	You must find a provider who will bill DSHS.
Hearing Aid Devices (see note below)	You must find a provider who will bill DSHS.
Early Support for Infants and Toddlers (ESIT) from birth to age 3.	Call 1-800-322-2588 for information
Maternity Support Services	Part of the DSHS First Steps Program – Call 1-800-322-2588
Mental Health, Inpatient Psychiatric Care and Crisis services	Inpatient care must be authorized by a mental health professional from the local Community Mental Health Agency. For more specific information call 1-800-446-0259.
Prenatal Genetic Counseling	
Pregnancy Terminations, Voluntary	Includes termination and follow-up care for any complications.
Sterilizations, under age 21	Must complete sterilization form 30 days prior or meet waiver requirements. Reversals not covered.
Transportation, for medical appointments	DSHS pays for transportation services to get you to and from needed non-emergency healthcare appointments. If you have a current Services Card, you may be eligible for transportation. Call the transportation service provider (broker) in your area. A list of Brokers can be found at http://maa.dshs.wa.gov/Transportation/Phone.htm. Your regional broker will arrange the most appropriate, least costly transportation for you.

* NOTE: Starting January 1, 2011 Dental Services; Eye glasses and fitting services; and Hearing Aid devices are no longer available for ADULTS age 21 and over through DSHS or the health plans.

Some Services are excluded and NOT paid for:

The examples in the list below are called exclusions, meaning these services are not covered, even if medically necessary. These services are not covered by your plan, PCCM or fee-for-service. If you get any of these services you may have to pay for them yourself. When a service is not a covered benefit, each health plan has a process to review your or your provider's request as an Exception to Rule. If you have a question about a benefit or service, call your health plan's Customer Service line.

Services Excluded	Comments
Alternative Medicines	Acupuncture, Christian Science practice, faith healing, herbal therapy, homeopathy, massage, massage therapy, or naturopathy.
Chiropractic care for adults	
Cosmetic or plastic surgery	Such as tattoo removal; face lifts; ear or body piercing; or hair transplants
Diagnosis and treatment of infertility, impotence, and sexual dysfunction	
Gender reassignment surgery	
Marriage counseling and sex therapy	
Personal comfort items	
Nonmedical equipment	
Physical exams needed for employment, insurance, or licensing	
Services not allowed by federal or state law	
Weight reduction and control services	This includes: weight loss drugs, products, gym memberships, or equipment for the purpose of weight reduction.

Do you have to pay for health care services?

Usually not. You have no copays... But if you get a service that is not covered by your health plan or DSHS you might have to pay.

To make sure you are not billed:

- Always carry both your Services card and your health plan ID card with you.
- Know the name of your health plan, Primary Care Provider (PCP), and/or Primary Care Case Management (PCCM) provider.
- Know your health plan and PCCM rules for getting care. There are times when you can be billed. If you don't follow the rules of your health plan or PCCM, such as going to a specialist without getting a referral, you may be billed for the service.

You may have to pay if:

- A service you get is not covered;
- A service you get is not Medically Necessary;
- You get care from a provider who does not work with your health plan (unless it is an emergency or pre-approved by your health plan);
- You sign an agreement to pay form; and
  - You get specialty care or equipment without a referral from your PCP; or
  - You get care that requires prior authorization, before it is approved.

If you are not in a health plan but getting care covered by DSHS fee-for-service, call the provider ahead of time to make sure they will bill DSHS for the service.

If you get a bill for a service you believe is covered, call your health plan or PCCM first. If you still need help, call DSHS at 1-800-562-3022.

What are your rights and responsibilities?

You have the right to:

- Help make decisions about your health care, including refusing treatment.
- Be informed about all treatment options available regardless of cost.
- Get a second opinion from another provider in your health plan.
- Get services without having to wait too long.
- Be treated with respect. Discrimination is not allowed. No one can be treated differently or unfairly because of their race, color, national origin, sex, sexual preference, age, religion, creed or disability.
- Speak freely about your health care and concerns without any bad results.
- Have your privacy protected and information about your care kept confidential.
- Ask for and get copies of your medical records.
- Ask for and have corrections made to your medical records when needed.
- Ask for and get information about:
  - Your health care
  - Your doctor and how referrals are made to specialists and other providers
  - How the health plan pays for care - call your health plan to ask for this information
  - All options for care and why you are getting certain kinds of care
  - How to get help with filing a grievance or complaint about your care
  - Your health plan's structure including their policies and procedures, practice guidelines, and how to recommend changes
  - Covered services.
- Receive the Members' Rights and Responsibilities at least yearly.
- Suggest changes to this policy.

You have the responsibility to:

- Help make decisions about your health care, including refusing treatment.
- Keep appointments and be on time. Call the office if you are going to be late or if you have to cancel the appointment.
- Give your providers the information they need to get paid for providing services to you.
- Show your providers the same respect you want from them.
- Bring your Services card and health plan ID card to all of your appointments.
- Learn about your health plan and what services are covered.
- Use health care services when you need them.
- Know your health problems and take part in making agreed upon treatment goals as much as possible.
- Give your providers complete information about your health so you can get the care you need.
- Follow your provider's instructions.
- Use health care services appropriately. If you do not, you may be enrolled in the Patient Review and Coordination Program. In this program, you are assigned to one primary care provider, one pharmacy, one prescriber for controlled substances, and one hospital for non-emergent care. You also stay in your present plan for at least 12 months.

Other Important Information

What happens if you have other health insurance?

Coordination of benefits happens when you have more than one health insurance plan at the same time. Please let the Coordination of Benefits Section at DSHS know if you have other health insurance. Call 1-800-562-3022 ext 16134. DSHS will verify your primary insurance coverage. If your primary insurance coverage is comparable (similar) to your managed care covered services, DSHS will disenroll you from the managed care program.

Your health plan must coordinate benefits with your primary insurance until you are disenrolled. To cover any co-pays or deductibles, be sure to call your plan's customer service number and let them know you have other insurance.

Third-party liability is when another party must pay for the health care you get because of an injury or accident. It is also called **subrogation.** For example, your auto insurance may pay if you are injured in an auto accident. Or workers' compensation may pay if you are hurt on the job. If you have an accident or injury, let your health plan know by calling the health plan's Customer Service center. The health plan will work with the party responsible for the accident/injury to recover any payments made on your behalf. If you get an insurance settlement, you may need to refund the health plan for any bills it paid related to the injury or accident.

How do health plans review new technology?

All health plans review new equipment, drugs and procedures to decide if they should be covered on a case by case basis. Some new equipment, drugs and procedures are still being tested to see if they really help. If they are still being tested they are called experimental or investigational. These services are covered after research and the plans determine they are more helpful than harmful. If you want to know more about this, call your health plan's Customer Service center.

How can you help stop health care fraud?

Health care fraud takes money from health care programs and leaves less money for real medical care. Here are some ways you can help stop fraud:

- Always carry a picture ID with you.
- Be careful about giving out your Social Security number.
- Do not give your Services card or health plan ID card or number to anyone other than a health care provider, clinic, or hospital, and only when receiving care.
- Never let anyone borrow your Services card or health plan ID card or number.
- Never sign a blank insurance form.

If you think fraud has taken place, call DSHS at:

- (800) 562-6906 to report Medicaid client fraud
- (360) 586-8888 to report Medicaid provider fraud

What are Advance Directives?

An Advance Directive puts your choices for health care into writing. The advance directive tells your doctor and family:

- What kind of health care you do or do not want if :
  - You lose consciousness,
  - You can no longer make health care decisions, or
  - You cannot tell your doctor or family what kind of care you want for any other reason.
- If you want to donate your organ(s) after your death.
- If you want someone else, a friend or family member, to decide about your health care if you can't.

Having an advance directive means your loved ones or your doctor can make medical choices for you based on your wishes. There are three types of advance directives in Washington State. These include:

(1) Durable Power of Attorney for Health Care. This names another person to make medical decisions for you if you are not able to make them for yourself.
(2) Healthcare Directive (living will). This is a written statement that tells people whether or not you want treatments to prolong your life.
(3) Organ Donation request.

Talk to your doctor, family, friends, and those close to you. Put decisions about your medical care in writing now. You can cancel an advance directive at any time. Your health plan, doctor, or hospital can give you more information about advance directives if you ask. You can also:

- Ask to see your plan's policies on advance directives, and
- File a grievance with your plan or DSHS if your directive is not followed.

What if you are unhappy with your health plan?

You have the right to file a grievance or appeal with your health plan if you are not happy with the way you have been treated or have been denied a medical service. The plan can help you file a grievance or an appeal.

Grievances or complaints can be about:

- A problem with your doctor's office,
- Getting a bill from your doctor, or
- Any other problems you may have getting health care.

Your health plan must let you know by phone or letter that they received your grievance or complaint within five working days. The plan must address your concerns within 30 days.

NOTE: The information in this section applies to you only if you are enrolled in a Healthy Options or Basic Health Plus health plan. If you are enrolled in PCCM, call DSHS at 1-800-562-3022 for help.

Things to know if a medical service is denied...there are time limits.

A **denial** is when your health plan does not approve or pay for a service that either you or your doctor asked for. When your health plan denies a service, it will send you a letter about the denied service. The letter will let you know about your rights if you or your doctors do not agree with the plan's decision. After you get a denial letter, you have 90 days to ask for an appeal of the plan's decision. Within 5 working days, the plan will reply in writing telling you they received your request.

An **appeal** is when you ask the health plan to review your case because you disagree with their denial. With written consent, you can have someone appeal on your behalf. You only have 10 days to ask for an appeal if you want to keep getting a service that you are already getting while the plan reviews its decision. Your plan will review and decide your appeal within 14 days. Your plan must tell you if it needs more time (up to 30 days) to make a decision. The plan must get your written permission to take more than 30 days to make a decision. In any case an appeal decision must be made within 45 days.

* NOTE: If you keep getting a service during the appeal process and you lose the appeal, you may have to pay for the services you received.

Is it urgent? For urgent medical conditions, you or your doctor can ask for an expedited (quick) review or hearing. If your medical condition requires it, a decision will be made about your care within 72 hours. To ask for an expedited appeal, tell your plan why you need the faster decision. If the health plan denies your request, your appeal will be reviewed in the same time frames outlined above. Your plan must make reasonable efforts to give you prompt oral notice if it denies your request for an expedited appeal. Your plan must provide written notice within 2 calendar days of its decision.

If you disagree with the appeal decision from the plan, you have the right to ask DSHS for a hearing within 90 days. A **hearing** is when you ask DSHS to review your case after your plan denied your appeal. DO NOT ask for a hearing from DSHS before you get the plan's decision about your appeal.

To ask for a DSHS Hearing:

- Call the Office of Administrative Hearings (www.oah.wa.gov) at 1-800-583-8271, or send a letter to P.O. Box 42489, Olympia, Washington, 98504-2489.
- Tell the Office of Administrative Hearings the reason for the hearing, what service was denied; the date it was denied; and the date that the appeal was denied. Also, be sure to give your name, address, and phone number.
- You may talk with a lawyer or have another person represent you at the hearing. If you need help finding a lawyer call the NW Justice CLEAR line at 888-201-1014, weekdays from 9:15 a.m. until 12:15 p.m., and Tuesdays from 3:30 p.m. until 6:15 p.m., or visit http://www.nwjustice.org/

After the hearing, DSHS will send you a letter with its decision. If you disagree with the hearing decision, you have the right to ask your plan for a review of your case by an **Independent Review Organization (IRO)**. An IRO is a group of doctors, who do not work for your plan. You have 180 days to call your plan and ask for a review by an IRO after you get the DSHS letter.

If you still do not agree with the decision of the IRO, you can ask to have the DSHS Board of Appeals review your case. You only have 21 days to ask the DSHS Board of Appeals to review the IRO's decision after getting your IRO decision letter. The Board of Appeals decision is final. You can ask for a Board of Appeals review by:

- Calling 1-877-351-0002 (TTD only: 360-664-6178), or
- Writing to the DSHS Board of Appeals at P.O. Box 45803 Olympia, WA 98504-5803.

Is your Privacy Protected by the health plans?

Yes! All health plans are required by law to protect your health information. Health plans, like DSHS, use and share protected health information about you to provide your health benefits. We use and share your information to carry out treatment, payment, and health care operations. We also use and share your information for other reasons as allowed and required by law. We have the duty to keep your health information private.

PHI stands for **P**rotected **H**ealth **I**nformation. PHI refers to health information such as medical records that include your name, member number, or other identifiers used or shared by health plans. Health plans and DSHS share PHI for the following reasons:

- Treatment - Includes referrals between your PCP and other health care providers.
- Payment - Your health plan may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical needs.
- Health Care Operations - Your health plan may use or share PHI about you to run the plan's business. For example, it may use information from your claim to let you know about a health program that could help you. Your PHI may also be used to see that claims are paid right.

Health plans may use or share your PHI *without* getting written authorization (approval) from you when:

- Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:
  - The information is directly related to the family or friend's involvement with your care or payment for that care; and
  - You have either orally agreed to the disclosure or have been given an opportunity to object and have not objected.
  - The law allows DSHS or your health plan to use and share your PHI for the following reasons:
- When the U. S. Secretary of the Department of Health and Human Services (DHHS) requires the plan to share your PHI. The law allows DSHS or your health plan to use and share your PHI for the following reasons:
  - Public Health and Safety: This may include helping public health agencies to prevent or control disease.
  - Health Care Oversight: Your PHI may be used or shared with government agencies. They may need your PHI for audits.
  - Research: Your PHI may be used or shared for research in certain cases, when approved by a privacy or institutional review board.
  - Legal or Administrative Proceedings: Your PHI may be used or shared for legal proceedings, such as in response to a court order. Your PHI may also be shared with funeral directors or coroners to help them do their jobs.
  - Law Enforcement: Your PHI may be used or shared with police to help find a suspect, witness or missing person. Your PHI may also be shared with other legal authorities, if we believe that you may be a victim of abuse, neglect or domestic violence.
  - Government Functions: Your PHI may be shared with the government for special functions, such as national security activities.
  - Workers Compensation: Your PHI may be used or shared to obey Workers Compensation laws.

Your written authorization (approval) is required for all other reasons not listed above. You may cancel a written approval that you have given to your health plan. However, your cancellation will not apply to actions taken before the cancellation.

If you believe your health plan violated your rights to privacy of your PHI, you can:

- Call your health plan and file a complaint. The plan will not take any action against you for filing a complaint. The care you get will not change in any way.
- File a complaint with the Secretary of the U.S. Department of Health and Human Services by writing to:

  Office for Civil Rights
  U.S. Department of Health and Human Services
  2201 Sixth Avenue – Mail Stop RX-11
  Seattle, WA 98121

Remember: This information is only an overview. Each health plan is required to keep your PHI private and give you written information annually about the plan's privacy practices and your PHI. Please refer to your health plan's Notice of Privacy Practices for additional details. You may also contact your health plan for more information.

Do health plans have quality improvement programs?

Yes. If you want a copy of your health plan's Quality Improvement Program description or progress report, please call your plan's Customer Service center.

How does a health plan pay providers?

Health plans make medical necessity decisions about your health care based on what you need and your benefits and coverage. Health plans cannot reward providers, employees, or other people to deny or limit your health care or encourage over-use or under-use of tests or treatments.

PRIMARY CARE CASE MANAGEMENT (PCCM) Clinics

For American Indian or Alaska Native family members

TRIBE	NAME AND LOCATION(S) OF CLINIC	PHONE NUMBER
Any tribe	Seattle Indian Health Board – Seattle	206-324-9360
Any tribe	NATIVE Health Clinic – Spokane	509-483-7535
Colville	Inchelium & Sanpoil Valley Health Center – Inchelium and Keller	509-722-7006
Colville	Colville Indian Health Center* - Nespelem and Omak	509-634-2900
Lower Elwha	Lower Elwha Health Center – Port Angeles	360-452-6252
Lummi	Lummi Tribal Health Center - Bellingham	360-384-0464
Nooksack	Nooksack Community Clinic - Everson	360-966-2106
Puyallup	Takopid Health Center – Tacoma	253-593-0232
Quileute	Quileute Health Center – LaPush	360-374-9035
Quinault	Roger Saux Health Center – Taholah	360-276-4405
Shoalwater Bay	Shoalwater Bay Wellness Center – Tokeland	360-267-0119
Spokane	David C. Wynecoop Memorial Clinic* - Wellpinit	509-258-4517
Tulalip	Tulalip Tribes Health Center – Tulalip	360-651-4511
Yakama	Yakama Indian Health Center* - Toppenish & White Swan	509-865-2102

*Federally recognized tribal status must be verified to receive services at this site.

ASURIS NORTHWEST HEALTH

How to Contact Us

Call us toll free at 1 (866) 240-9560 or TTY/TDD at 711 Monday-Friday, 7:30 a.m. to 5:00 p.m. Asuris uses the AT&T Language Line for oral translation services for over 140 different languages. You can ask for this if English is not your primary language. There is no cost to you for this service.

You can also write to us at:

Asuris Northwest Health
P.O. Box 91130, MS BR320
1800 Ninth Avenue
Seattle, WA 98111

Provider Network Limits

As an Asuris member you can select a Primary Care Provider (PCP) of your choice. If you do not select a PCP, we will choose one for you. Asuris works with individual providers and groups of providers called Medical Group Practices (MGP). If your PCP is in an MGP, they will refer you to a specialist or facility (like a hospital) in the same MGP for care your PCP can't give you. You can call us to ask if your PCP is part of an MGP. If you want to find out if the specialists and facilities you go to are part of your PCP's MGP, call your PCP. Even if a specialist or facility is part of Asuris, you can only go to those in your PCP's MGP. If your PCP is not in an MGP, they can refer you to any Asuris Healthy Options specialist or facility.

Fraud Hotline

We know most of our members are careful to be sure that only claims for health care they got are sent to us. However, sometimes we get false claims. You can call us in strict confidence at 1(800) 922-4321 to tell us if:

- Someone else has used your Asuris member card or
- You know we were billed for care you did not get.

How to Get Health Care from Asuris

You can get check-ups (well-child exams), family planning services, routine care and shots from your PCP. Call your PCP's office to make an appointment. If you need care when your PCP's office is closed, call the PCP's office anyway. Someone will answer. The doctor who is taking your PCP's calls will call you back.

When You Are Sick or Hurt

Call your PCP. Your PCP will give or approve the medical care you need. Some illnesses get worse as the day goes on. CALL YOUR PCP EARLY before a problem gets bad. It's better to take care of a medical problem during the day.

Emergency and Urgent Care

You can call your PCP's office 24 hours a day, 365 days a year. Someone from your PCP's office will help you get the care you need. In a true life threatening emergency, you can always call 911 or go to the nearest emergency room without a referral from you PCP.

How do I get a referral to specialists?

Call your PCP to get medical care.

- If you need care your PCP can not give you, your PCP will refer you to a specialist and tell us they referred you.
- We will send a referral letter to you, your PCP and the specialist.
- Take this letter to the specialist. It tells them Asuris is aware of the referral.
- We will not pay for referrals for services that are not covered by Healthy Options.

Special Programs

Blood Glucose Monitor Program

We offer you the ability to receive a new Bayer blood glucose meter at no cost if you have diabetes and use a blood glucose meter with testing strips to monitor your blood sugar. Bayer meters and test strips are on our Preferred Medication List. There are two different meters to choose from. Meters and an instructional video are shipped to our members with diabetes by calling 1 (888) 787-0233.

Special Beginnings®

Special Beginnings® is a program that gives moms-to-be 24-hour access to a nurse trained in women's health, pregnancy, and birth. Special Beginnings® helps moms-to-be deliver healthy, full-term babies and gives you peace of mind. If you enroll in the program, you will receive educational materials that fit your needs. Nurses will have regular contact with participants who are at high risk

This program is for all moms-to-be, not just those who are high risk. Each member receives a special health assessment to find prenatal risk factors. You will also be told about signs and symptoms that could signal a problem. A nurse is assigned for high-risk members and the member's doctor or midwife is told of the participant's risk status and participation in the program.

To ask questions about the program, call Special Beginnings® at 1 (888) 569-2229.

Columbia United Providers
19120 SE 34th Street, Suite 201
Vancouver, WA 98683

Office Hours: Monday - Friday 8:00 am to 5:00 pm
Call: 1-800-315-7862
Website: www.cuphealth.com

Columbia United Providers (CUP) is a managed care plan for people receiving Medical Assistance from DSHS. CUP promotes high quality health care and medical services in multiple counties in Washington. CUP has a large network of Primary Care and Specialty Care providers available to members in their local community. Case Management and Health Education programs are offered for members with chronic health conditions or special healthcare needs. Friendly Member Services Representatives are available to help you understand and use your health benefits.

When You Select Columbia United Providers:

1. Learn About Your Health Plan.
   This handbook gives you information you need to know about using your health plan coverage.
2. Choose and Make an Appointment with your Primary Care Provider (PCP).
   If you have questions about your PCP assignment, call CUP.
3. Whenever you need medical care, call your PCP office.
   Your PCP knows you best and can usually get you the best care in the fastest time.
4. Carry you ID cards and picture ID.
   Always carry both your CUP ID and DSHS Services cards. Show the cards for all the medical and pharmacy services you get. Be ready to show picture ID if asked.
5. If it's a life threatening emergency!
   Call 9-1-1 or go to the nearest emergency room.
6. Report all your changes.
   If you have a new address, phone number, or a new baby; CUP and DSHS need to know to make sure you are covered.
7. When you can't make an appointment time or you will be late...
   Call your PCP or other provider to let them know. Your appointment time can be given to someone else who may need care.

How Do I Get a Primary Care Provider (PCP)?

Some doctors, whether they offer primary care or specialty services, are part of a Medical Group Practice. A hospital and other types of health care providers may also be part of a Medical Group Practice. Primary care providers, specialists, and other health care service providers in a Medical Group Practice may or may not provide care in the same building, but are still part of one large group practice.

CUP members are assigned to a PCP or medical group practice. If you have questions about choosing a PCP, you can call the PCP office or medical group practice and the staff will help you choose a PCP. This should be done within the first thirty days of starting eligibility with CUP. If you do not choose a PCP, CUP will choose a PCP for you.

If your PCP is part of a medical group practice that has specialty care services within the medical group practice, you must see the specialists within the same medical group practice. If it is medically necessary for you to see a type of specialist not available in the medical group practice, your PCP will help you select a specialist and ask for approval of the visit for you.

Your PCP must coordinate all of your care. If you are sick, injured, or need advice, call your PCP.

You may ask to change your PCP at any time by calling CUP.

What if I need care after hours or have an emergency?

Call your PCP first – even if the office is closed, there will be someone to take your call 24 hours a day and help you decide what to do. CUP is contracted with seven (7) urgent care centers; call CUP or check CUP's website for a listing. If you have a life-threatening emergency, call 911, or go to the nearest emergency room.

Get Routine Health Exams

A healthy lifestyle is good. Get your preventive health check-up. Physical exams and check-ups help you to live a healthier and happier life. A health exam helps your PCP find medical health problems early. Early care from your PCP can help control serious medical problems. Your PCP can help you. Follow your PCP's advice. Take control of your health. If you have questions about sports physicals, call CUP.

CUP has FREE information and support for anyone who has a health condition they would like help with. For more information please call CUP's Member Services Department.

Special Health Care Needs: If you or your child has a special health problem or long-term illness, call CUP. We will tell you if you may be able to receive extra benefits and direct access to specialists.

What if I need medicine?

- Prescriptions must be filled at a CUP contracted pharmacy. Call CUP for a full list of pharmacies.
- If you need a prescription and CUP and your pharmacy are closed; call Express Scripts at 1-866-347-3514.
- Generic drugs are required on all drug list items, when available.

Community Health Plan of Washington was founded in 1992 by a network of community health centers across Washington State. We are a nonprofit organization, founded by and rooted in the communities we serve. We invest and foster growth in the communities where you get your care.

For more information about our care or about clinics, providers, pharmacies, and hospitals you can visit in your community:

- Visit our web site: www.chpw.org.
- Phone the Community Health Plan customer service team at 1-800-440-1561 voice. If speech or hearing impaired, call TTY 1-866-816-2479 toll free or local 206-613-8875.
- Email our customer service team at customercare@chpw.org.

Your Care with Community Health Plan

With Community Health Plan, the focus is on getting to know you—your health, your family, and your community.

Moms and Babies: Community Health Plan takes care of a lot of pregnant women and new moms. We know how important and special your new arrival is. Our Children First™ program rewards you for getting care when you are pregnant and for getting Well Child checkups after your baby is born. Children First™ moms and kids can get gifts such as:

- Free car seats
- Free children's books
- Free baby grooming kits

Singles and Families: You work hard and do your best, just like us. So we understand that being sick means more than a fever or missed school. It can also mean lost wages and additional work in an already stressful day. We work as hard as you do to keep your family healthy. And if you need information right now, our 24/7 Nurse Advice Line is just a phone call away.

Seniors: Sometimes getting older can be hard work — but getting medical care shouldn't be. It's easier to relax and enjoy life when you know that your doctors, specialists, and pharmacies may be as close as your local community health center.

Special Needs: If you have complex medical needs, it can be hard to find hassle-free support. Community Health Plan works directly with you to plan your care across our entire system of providers. We help you to manage your medical needs — and the paperwork that comes with them. Because many of our members have special health issues, we also work to voice your needs at the local, state, and even federal levels.

Contact Community Health Plan

For information, including:

- Providers, clinics, drug stores, and hospitals in the Community Health Plan network.
- Specific services, treatments, and drugs covered, approvals needed, and any limits.
- How you can get care when your clinic is not open.
- How we choose the drugs our providers prescribe and how to get your prescriptions filled.
- How we protect your privacy.
- How the Plan monitors and maintains the quality of its care and customer service.
- Programs that help you manage chronic (long-term) health conditions, such as asthma and diabetes.

Contact our customer service team 8 a.m. – 5 p.m. Monday–Friday

- Voice 1-800-440-1561 (toll free)
- For speech or hearing impaired TTY 1-866-816-2479 (toll free) or local 206-613-8875
- Email customercare@chpw.org

See the Community Health Plan website: http://www.chpw.org/

Nurse Advice Line FREE for members 24 hours a day, 7 days a week

- Voice 1-866-418-1002 (toll free)
- For speech or hearing impaired TTY 1-866-418-1006 (toll free)

GroupHealth®

Group Health Cooperative has many doctors you can see. You can also go to many hospitals and pharmacies. We want to help keep you and your family healthy. When you are ill, we want to give you the best care possible. That's why your plan covers checkups, prenatal care, vision care, well-child care, and specialty and hospital care.

Group Health Convenience

Group Health Cooperative owns medical centers and facilities throughout Washington and North Idaho. When you choose care with Group Health and get your care at Group Health medical centers, getting the most from your health plan becomes a lot easier. Your personal physician, the lab, and pharmacy are all in one location. So driving around town is now a thing of the past.

Contact Information

Customer Service: Monday through Friday from 8 a.m. to 5:30 p.m.

Seattle area: 1-206-901-4636;

Statewide: 1-888-901-4636; or

Email: info@ghc.org

TTY Relay: For members who are hearing- or speech-impaired.

Washington: 1-800-833-6388 or 711; **Idaho:** 1-800-377-3529 or 711

Consulting Nurse Service: 24-hour health advice, and more.1-800-297-6877 or 206-901-2244

Mail-Order Pharmacy: Have your prescription refills mailed to your home or work with free delivery 1-800-245-7979.

Notification Line: If you are admitted to a hospital outside our service area, call the Notification Line within 24 hours, or as soon as possible 1-888-457-9516

Language interpreters: You have the right to professional language assistance free of charge. If you need an interpreter, please call Customer Service at 1-888-901-4636.

MyGroupHealth for Members

When you join Group Health, you also can use our website at www.ghc.org. It is called MyGroupHealth for Members. On this site you can refill prescriptions, e-mail your care team, request appointments, and access your online medical record. To register and see how it works, go to www.ghc.org, complete a one-time ID verification process and click "Tour Our Online Services."

Your network

The Group Health Plan gives you access to Group Health's many physicians plus thousands of contracted doctors. If you would like a list of Group Health doctors you can see, please go to www.ghc.org or contact Customer Service at 1-888-901-4636 and tell them where you live. Our Customer Service staff can tell you, or send you information, about providers' qualifications, languages spoken, any practice restrictions, and availability.

Appointments

When you want to see your doctor, just call their office and ask for a time to come in. Or log on to MyGroupHealth at www.ghc.org and request an appointment online. Group Health strives to offer you same-day appointments. If you go to a Group Health medical center, call your doctor's office in the morning. You might be able to see your doctor or a member of the Medical Team that day.

Special Services

Free & Clear® Quit For Life™ Program
This service is free to help you quit smoking. For information, please call 1-800-992-2279.

Group Health Resource Line
This line helps you learn about health education. You also learn about community resources and support groups in your area. Call the volunteers at 1-800-992-2279 or e-mail us at resource.l@ghc.org.

Healthwise® Knowledgebase
You can get information on more than 5,000 health care topics at www.ghc.org

Health improvement classes and services
For information on baby care, diabetes, heart care, alcohol or drug abuse, AIDS, and violence prevention, call 1-800-992-2279.

Speech, Language, and Learning Services
You can get help here with speech and learning problems. Call 1-800-645-6799.

KAISER PERMANENTE®

We offer many health services. We provide these services at medical offices and participating hospitals throughout our Northwest region.

Generally, you must get all of your care from Kaiser Permanente. We will only pay for health care you get from Kaiser Permanente or that a Kaiser Permanente health care provider has approved and arranged for you.

We have many convenient locations. You can pick one that's best for you. A directory of offices and hospitals is available at www.kp.org or you can request a directory from Membership Services.

Whenever you have questions about your care, benefits, or the services we provide, just ask our Membership Services staff.

IN PERSON
We have staff located in most Kaiser Permanente medical offices and hospitals.

BY PHONE
Call Membership Services Monday through Friday, 8 a.m. to 6 p.m.
Portland area.....503-813-2000
All other areas 1-800-813-2000
TTY.....1-800-735-2900
Language interpretation services 1-800-324-8010

Reminder: You can call Kaiser Permanente from Washington state by dialing our toll-free number, 1-800-813-2000. You can use this number to make an appointment, talk to an advice nurse, or speak to Membership Services. You can also ask to speak to another department.

ONLINE
Contact Membership Services by e-mail when you log on to www.kp.org. New members often have questions about choosing a primary care provider, getting emergency care, or making the most of a medical office visit. Our staff can answer your questions. They can also replace your Kaiser Permanente Healthy Options ID card if you lose it.

Need an appointment?

Call the primary care appointment number for the medical office where you want to go. We'll make an appointment for you with a provider who is taking new patients. We'll ask if you'd like that provider to be your primary care provider. You can also decide after you've seen the provider.

Your primary care provider (PCP) will provide or arrange for most of your care. If you need to see a specialist, your PCP will give you a referral and arrange for your visit. Once you've seen a Kaiser Permanente specialist, you don't need another referral to see the same specialist for the same condition again.

Sometimes your Kaiser Permanente provider might refer you to a non–Kaiser Permanente specialist. Your Kaiser Permanente provider will give you a written referral. It's called an "Authorization for Outside Medical Care."

The referral may limit the number of times you can see the non–Kaiser Permanente provider. It may set a limit on how many weeks you can use these services. Contact your Kaiser Permanente provider if you need more visits.

Advice nurse:

If you are not sure if you need to see a doctor, or if you don't know how to get care, you can call an advice nurse. A registered nurse will answer your health care questions 24 hours a day, 7 days a week. There is no cost to you.
To speak to an advice nurse during regular hours, call your local medical office.
After hours, call: Portland area 503-813-2000
Vancouver area 1-866-420-2244
All other areas 1-800-813-2000
TTY 1-800-735-2900
Language interpreter services 1-800-324-8010
Oncology advice in the Longview-Kelso area 360-636-5559

Urgent care:

Urgent care is for problems that come up suddenly and should be taken care of right away to keep them from getting worse, but they aren't emergencies.

Your urgent care options depend on the time and day. During regular medical office hours, call for an appointment at one of our medical offices. You might be able to get a same-day appointment.

On weekday nights and on weekends and holidays, use one of the urgent care locations near you. Please check the hours the urgent care clinic is open. You may also call the advice nurse for help getting

In Portland, Longview, and Vancouver, you don't need an appointment for urgent care medical services.

***When your local urgent care location is closed on a holiday, call the advice nurse.*

Pharmacy services

You get your covered prescriptions filled at our pharmacies. Pharmacies are located in most of our medical offices. You can use the phone or the Internet to order prescription refills. To order on the internet, you'll need to first register as a member on www.kp.org. The web page will tell you how. To order a refill, go to the website. Have your Kaiser Permanente ID card and prescription number(s) handy. To order refills by phone, call the refill phone number on your prescription packaging. You may call at any time.

Since 1980 Molina Healthcare has been a leader in providing quality healthcare to those who depend on government assistance. Our commitment to our members has made us a national leader in providing affordable healthcare to families and individuals. During this time, we've become one of the most experienced managed healthcare companies in the country.

We work with Medicaid and Medicare, among other government programs. Currently we provide healthcare assistance to approximately 1.4 million members in ten states. Molina Healthcare of Washington is accredited by National Committee of Quality Assurance (NCQA), a private non-profit organization dedicated to improving healthcare quality.

Molina Healthcare Member Services

We are open Monday through Friday, from 8:00 a.m. until 5:00 p.m. at (800) 869-7165 to answer all of your questions and concerns.

Member Services can help you find a Primary Care Provider (PCP) in your area or change to a different PCP. If you have questions about an authorization or denial, we can get help for you from our Medical Department. If you call after business hours, you can leave a message and we will call you back the next business day.

We can help you if you do not speak English. If you need help in another language, choose your language at (800) 869-7165. If your language is not listed, we will get an interpreter on the line. This service is at no cost to you. If you are hearing impaired, please use TDD at (877) 665-4629.

Nurse Advice Line

When you have questions about your healthcare; call the 24-hour Nurse Advice Line at (888) 275-8750 English or (866) 648-3537 Spanish.

Group Practices

Some PCPs and Specialists are in a Network Group Practice. These network groups include PCPs, Specialists, hospitals, and other health care providers. When you choose a PCP in a Network Group Practice, your PCP will refer you first to specialists and facilities within the network group. If a PCP is in a network group, Molina Healthcare's Provider Directory shows the name of the Network Group Practice under the PCP's address.

Note: If your Molina Healthcare ID Card has WVMC next to your PCP's name, then your PCP is part of a Network Group Practice. Contact your PCP for a list of Specialists in that Network Group Practice.

Prescriptions

Molina Healthcare has contracts with most pharmacies. You must get your drugs from one of these pharmacies. Call Member Services at (800) 869-7165or go to the Molina Healthcare website for more information.

Molina Healthcare Extra Services

- If you are pregnant and complete our Prenatal Program, you can receive an infant car seat or booster seat
- If you are pregnant and complete our After Delivery Care Program, you can receive a digital thermometer.
- If your child completes a well child exam, you can receive a gift

Disease Management

Molina Healthcare has programs to help our members with the following chronic diseases:

- Asthma
- Diabetes
- Cardiovascular conditions: hypertension, coronary artery disease, or congestive heart failure
- Chronic Obstructive Pulmonary Disorder (COPD)

You will be enrolled in one or more of these programs if your claims or your provider tell us you have any of the conditions above. As a program member you will receive:

- Newsletters
- Vital care tips specific to the condition
- RN Care Manager care if needed

Stop Smoking Program (Free and Clear®)

Smoking is a risk factor for your health and those around you. Our Free and Clear® stop smoking program can make it easier to quit.

If you would like to enroll or if you have questions, please call the Washington State Quit Line at: (877) 270-7867 English, (877) 266-3863 Spanish, (877) 777-6534 TDD

The Molina Healthcare Website

The Molina Healthcare website is a great place to find information you need. Just go to www.molinahealthcare.com and click on Members, then choose Washington and you can:

- Search for a provider
- Request a temporary ID card
- Request to change your Primary Care Provider (PCP)
- Read about your benefits
- Check our approved list of prescription drugs
- Search for Health and Wellness information

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

How to Contact Us

Call us toll free at 1 (800) 669-8791 (TTY/TDD 711) Monday-Friday, 7:30 a.m. to 5:00 p.m. Regence uses the AT&T Language Line for oral translation services for over 140 different languages. You can ask for this if English is not your primary language. There is no cost to you for this service.

You can also write to us at:

Regence BlueShield
P.O. Box 21267, MS BR320
1800 Ninth Avenue
Seattle, WA 98111-3267

Provider Network Limits

As a Regence member you can select a Primary Care Provider (PCP) of your choice. If you do not select a PCP, we will choose one for you. Regence works with individual providers and groups of providers called Medical Group Practices (MGP). If your PCP is in an MGP, they will refer you to a specialist or facility (like a hospital) in the same MGP for care your PCP can't give you. You can call us to ask if your PCP is part of an MGP. If you want to find out if the specialists and facilities you go to are part of your PCP's MGP, call your PCP. Even if a specialist or facility is part of Regence, you can only go to those in your PCP's MGP.

Women can go to any Regence women's health care provider for maternity and woman's health care. If your PCP is not in an MGP, they can refer you to any Regence Healthy Options specialist or facility.

Fraud Hotline

We know most of our members are careful to be sure that only claims for health care they got are sent to us. However, sometimes we get false claims. You can call us in strict confidence at 1(800) 922-4321 to tell us if:

- Someone else has used your Regence member card
- You know we were billed for care you did not get.

How to Get Health Care from Regence

You can get check-ups (well-child exams), family planning services, routine care and shots from your PCP. Call your PCP's office to make an appointment. If you need care when your PCP's office is closed, call them anyway. The doctor who is taking your PCP's calls will call you back.

When You Are Sick or Hurt

Call your PCP. Some illnesses get worse as the day goes on. CALL YOUR PCP EARLY before a problem gets bad. It's better to take care of a medical problem during the day.

Emergency Care and Urgent Care

You can call your PCP's office 24 hours a day, 365 days a year. Someone from your PCP's office will help you get the care you need. In a true life threatening emergency, you can always call 911 or go to the nearest emergency room without a referral from you PCP.

Referrals to Specialists

- Call your PCP to get medical care.
- If you need care your PCP can not give you, your PCP will refer you to a specialist and tell us they referred you.
- We will send a referral letter to you, your PCP and the specialist.
- Take this letter to the specialist. It tells them Regence is aware of the referral.
- We will not pay for referrals for services that are not covered by Healthy Options.

Special Programs

Blood Glucose Monitor Program

We offer you the ability to receive a new Bayer blood glucose meter at no cost if you have diabetes and use a blood glucose meter with testing strips to monitor your blood sugar. Bayer meters and test strips are on our Preferred Medication List. There are two different meters to choose from. Meters and an instructional video are shipped to our members with diabetes by calling 1-888-787-0233.

Special Beginnings®

Special Beginnings® is a program that gives moms-to-be 24-hour access to a nurse trained in women's health, pregnancy, and birth. Special Beginnings® helps moms-to-be deliver healthy, full-term babies and gives you peace of mind. If you enroll in the program, you will receive educational materials that fit your needs. Nurses will have regular contact with participants who are at high risk

This program is for all moms-to-be, not just those who are high risk. Each member is given a special health assessment to find prenatal risk factors. You will also be told about signs and symptoms that could signal a problem. A nurse is assigned for high-risk members and the member's doctor or midwife is told of the participant's risk status and participation in the program.

To ask questions about the program, call Special Beginnings® at 1-888-569-2229.

Glossary of Important Terms

Advance Directive
Puts the patient's choices for health care into writing. It may also name someone to speak for the patient if he or she is not able to speak. May include a Durable Power of Attorney for Health Care or a Directive to Physicians or both.

Appeal
When the member asks the health plan to review a denied service or a denied referral for a service.

Basic Health Plus (BH Plus)
A Medicaid managed care program for children who are under age 19, live in Basic Health households and meet the eligibility guidelines for Medicaid. This program allows children to get extra services, such as dental and eyeglasses, not covered by Basic Health.

Children's Health Insurance Program (CHIP)
CHIP is a medical program for kids under 19 with family incomes too high for Medicaid. People on this plan will pay a premium for each child.

COB
Coordination of benefits. Happens when the member is covered by more than one health insurance plan at the same time. The primary insurance plan must pay first for all covered benefits. All DSHS medical programs are secondary to the primary insurance coverage.

CSO
Community Service Office where medical eligibility determinations are made. Local offices are found throughout the State. See the website at for specific locations and phone numbers. https://fortress.wa.gov/dshs/f2ws03esaapps/onlinecso/findservice.asp

DSHS
The Washington State Department of Social and Health Services.

Durable Power of Attorney for Health Care
An advance directive that names another person to make decisions for a patient if the patient is not able to make decisions for herself or himself.

Emergency
A situation when someone has a sudden or severe medical problem that needs medical care right away.

First Steps
A program for pregnant women that provides:
- Nursing services
- Social work services
- Health education and counseling
- Transportation for maternity care appointments
- Nutritional services

Formulary
A list of prescription drugs developed by doctors and pharmacists. Drugs are placed on the formulary based on a review of their safety, effectiveness, and cost. Formulary drugs are approved for use or coverage by the plan and will be given to covered enrollees by drug stores in the network.

Grievance
A spoken or written complaint about anything that an enrollee is not happy with except for a denied service.

HCA
Washington State Health Care Authority. The HCA administers the Basic Health Plan. DSHS and the HCA co-administer the Basic Health Plus program.

Healthy Options Program
The name given to the DSHS Medicaid Managed Care medical insurance health program provided to children, pregnant women and families receiving TANF benefits.

ID card and Services card
ID Cards from health plans and Services cards from DSHS are sent to all covered family members. Patients must show their plan ID card and DSHS Services card when they get care or when they go to the drug store.

IRO
Independent Review Organization.

Living Will
A document that gives the patient's instructions for the kind of care he or she wants to get if he or she is seriously ill and not able to communicate.

Managed Care
A health care program where enrollees pick a plan and go to one clinic or doctor who will be your Primary Care Provider (PCP). Your PCP will give you the care you need or have you go to a specialist. In Medicaid, you may still get some services that your health plan does not provide through fee-for-service (such as dental care or eyeglasses).

Maternity Benefits Program
A Medicaid program for pregnant women who are Basic Health members and meet the income guidelines for Medicaid. This program allows pregnant women extra services not covered by Basic Health with no co-pays, no premiums, and no waiting for pre-existing conditions.

Medicaid
The state and federal health care program for low-income eligible people.

Medical Necessity
Each health plan makes Medical Necessity determinations by evaluating health care services for diagnosis, treatment of an illness, injury, disease, or its symptoms.
A medically necessary service must be:

- In line with current standards of practice (evidence based)
- An effective treatment for the patient's illness, injury, or disease.
- No more expensive than other equally effective services.
- Not primarily for the patient's or the doctor's convenience.

Prior Authorization
The review and approval of requested services by a health plan. Some services require a prior authorization from the health plan before the service can be paid.

Referral
The primary method used to get specialty services. Some services require a referral from the PCP before the specialty provider can be paid.

Washington State
Department of Social
& Health Services

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